Financing Delivery System Reform through Value-Based Reimbursement Methodologies

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Overview: Value-Based Purchasing

- Implement reimbursement methodologies that **reward value and quality** by creating financial incentives for providers
- States are currently implementing a variety of payment models, including:
  - Per Member Per Month (PMPM) Care Management payments
  - Performance incentives
  - Shared savings/shared risk payments
  - Bundled/Episodic payments
  - Global payments

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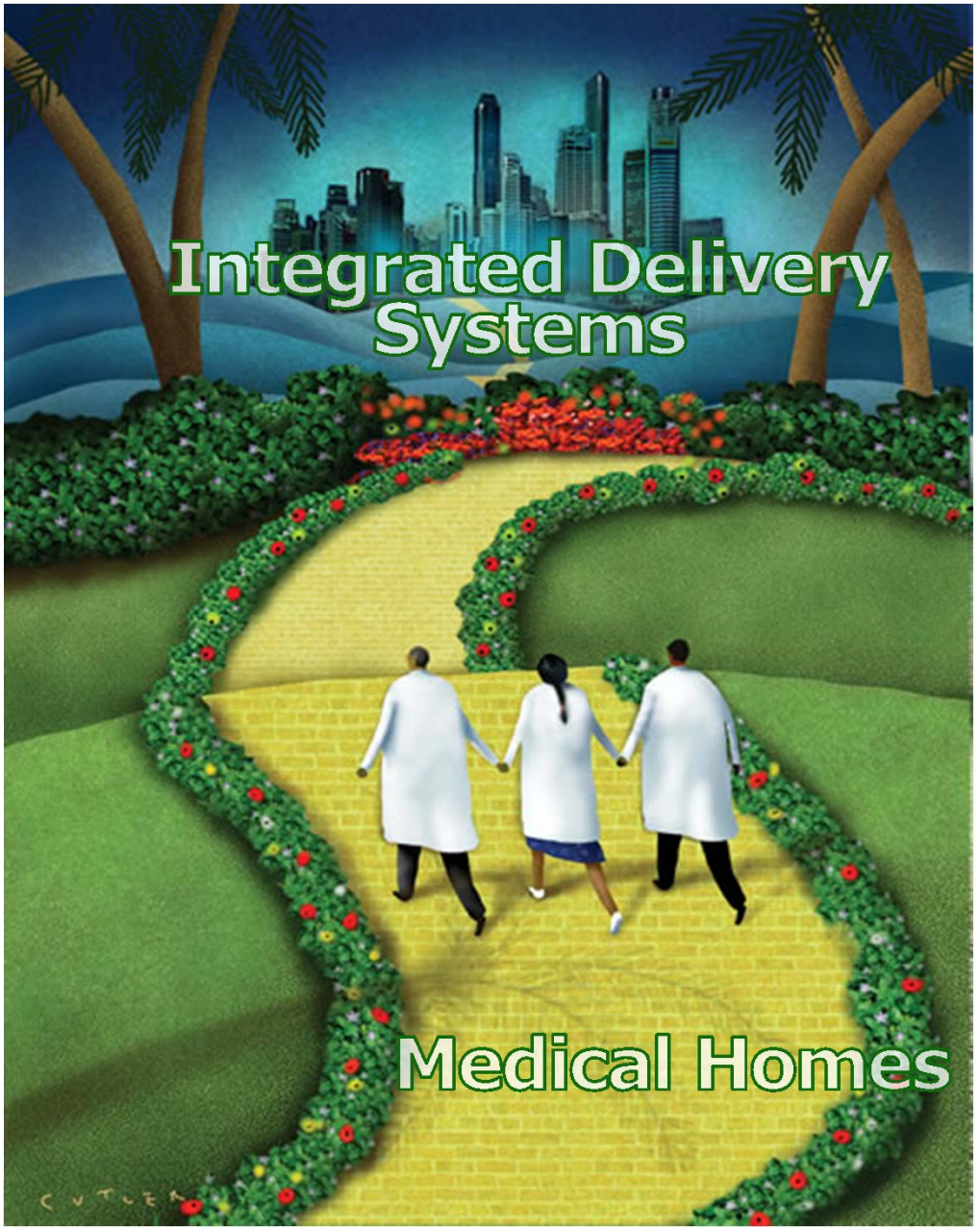
Where do you want to go?



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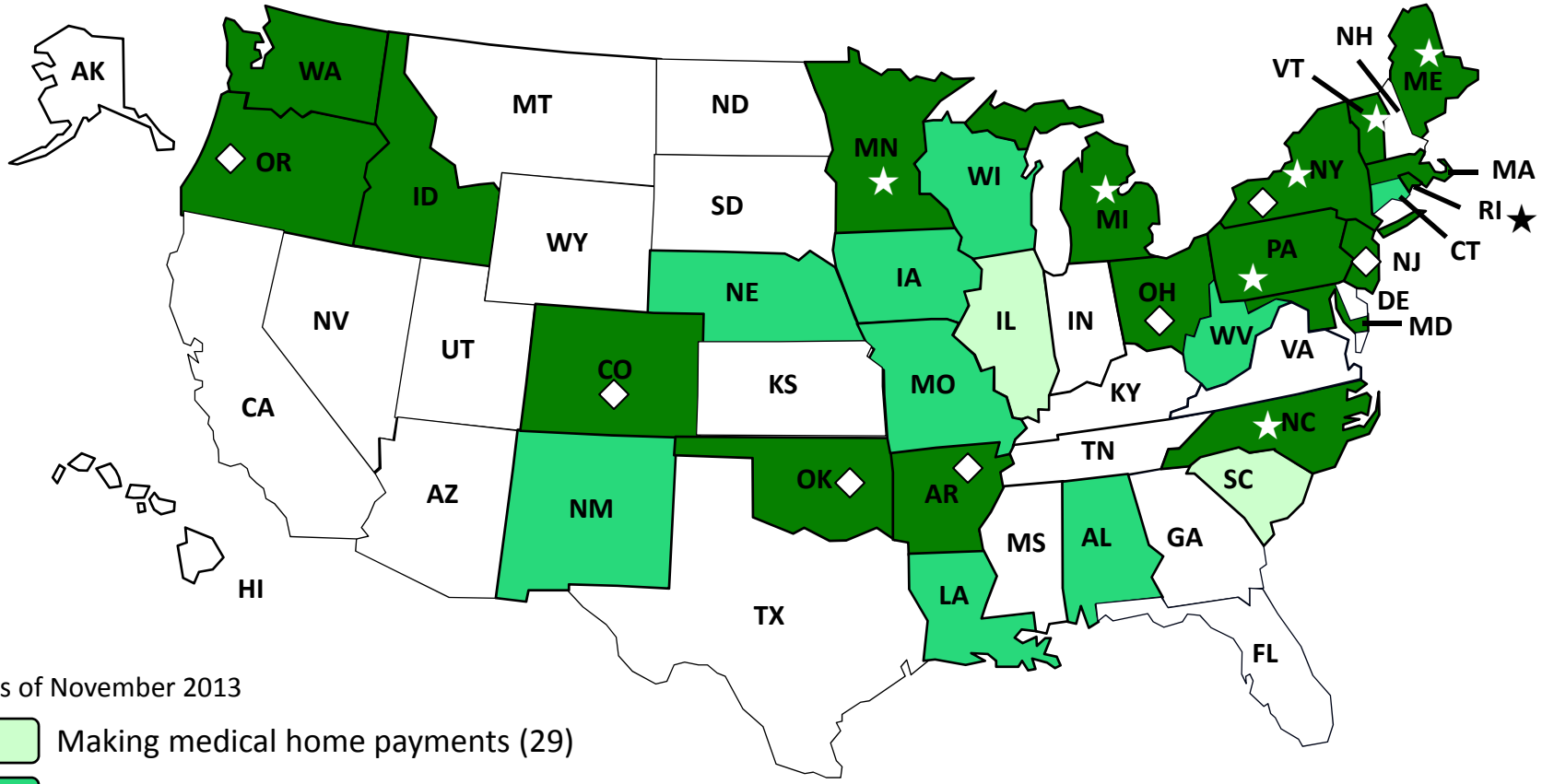
Medicaid PCMH Payment Activity



As of November 2013

- Making medical home payments (29)
- Payments based on provider qualification standards (27)
- Payments based on provider qualification standards, making payments in a multi-payer initiative (18)
- ★ Participating in MAPCP Demonstration (8: ME, MI, MN, NY, NC, PA, RI, VT)
- ◆ Participating in CPC Initiative (7: AR, CO, NJ, NY, OH, OK, OR)

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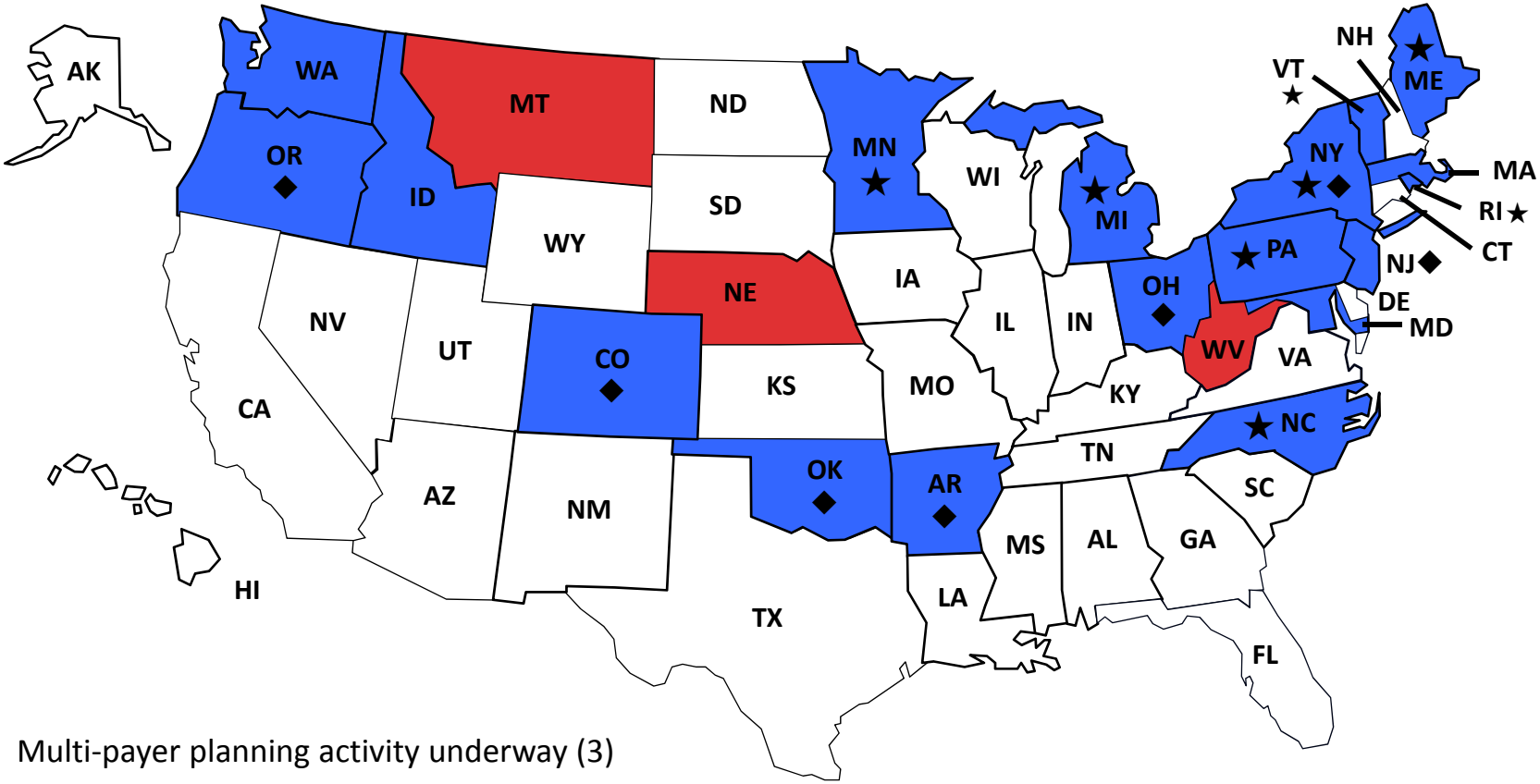
http://www.nashp.org/med-home-map

Medicaid-only PCMH Programs

	Scope	Payment Strategy	Payment Aligned with Qualification Standards	Additional Information
Connecticut: HUSKY Health Person-Centered Medical Home Initiative	• Statewide; • Serves Medicaid, CHIP, and Charter Oak Health Plan enrollees	• Enhanced Fee Differential Payment • Eligible for performance-based and improvement-based PMPM payments	• Practices must meet Level 2 or Level 3 NQCA PCMH recognition standards; • Glide Path option for practices to participate and achieve NCQA recognition	• State is pursing alternative payment methods and intents to develop a prospective PMPM for participating providers by 2014
Illinois: Illinois Health Connect	• Statewide PCCM program serving Medicaid, CHIP, and state-funded program for children (1.5 million residents)	• Enhanced FFS rate • Care Management PMPM (tiered based on patient age) • Eligible for performance-based payments	• N/A; Practices sign a participation agreement	• Performance payments totaled over $3.3 million in 2009 to 4,200 PCPs
New York: Patient-Centered Medical Home Program	• Statewide • Serves individuals enrolled in Medicaid, Family Health Plus or Child Health Plus	• Medicaid FFS: Enhanced FFS rates for certain E&M and preventative medicine codes • Managed Care: PMPM incentive payment	• Practices must be NCQA recognized • All payments tiered by level of NCQA recognition – level 3 practices receive the largest enhanced FFS rates and PMPM payments	• Enhanced FFS rats also vary by type of provider – hospital outpatient clinics (including FQHCs) receive lower payments than office-based practitioners

Multi-Payer PCMH Activity



- Multi-payer planning activity underway (3)
- Multi-payer payments to medical homes underway (18)
- ★ Participating in Multi-payer Advanced Primary Care Practice Demonstration (8: ME, MI, MN, NY, NC, PA, RI, VT)
- ◆ Participating in Comprehensive Primary Care Initiative (CPCi) (7: AR, CO, NJ, NY, OH, OK, OR)

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SOURCE: National Academy for State Health Policy. "Medical Home and Patient-Centered Care." Available at: www.nashp.org/med-home-map. As of August 2013.

Select Care Coordination Payments to Providers in Multi-Payer Medical Home Initiatives

State Initiative	Per member per month range	Adjusted for Patient Complexity or Demographic	Adjusted for Medical Home Level	Lump Sum Payment	Financial Incentive Based on Quality
TOTAL (n=5)	**$1.20 - $79.05**	**3**	**2**	**1**	**3**
Maryland	$3.51 - $11.54	▲	▲		▲
Minnesota	$10.14 - $79.05	▲			
Pennsylvania	$2.10 - $8.50	▲		▲	▲
Rhode Island	$5.00 - $6.00				▲
Vermont	$1.20 - $2.39		▲		

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Community Care Team Payment Models Financed by Public & Private Payers

	Scope	Payers	Payment Strategy	Additional Information
Alabama: Patient Care Networks	• 4 teams • 3,100 enrolled patients	• Medicaid (through Patient 1st PCCM program)	• Eligible for up to $50,000 to cover start-up costs • $3-5 PMPM; variable based on ABD status	• Regional (select counties in 4 regions) • Stepping stone to development of risk-bearing RCOs (legislation passed in 2013)
Vermont: Community Health Teams	• 14 health teams • 400,000 eligible patients	• Medicaid, Medicare, private plans, some self-insured employers including state employees	• $350,000 annually per team, divided among participating payers, to support general patient population of ~20,000	• Statewide • "Extender" staff focus on care for elderly in the community. • Medicare participates through MAPCP Demonstration.
Michigan: Physician Organizations	• 36 physician organization • 970,000 eligible patients	• Medicaid, Medicare, private plans, some self-insured	• Care Coordination: $4.50 PMPM for Medicare, $3 PMPM for Medicaid and private. • Incentives: $3 PMPM (required to redistribute at least 80% to practices).	• Statewide • Affiliated with Blue Cross Blue Shield of Michigan's Physician Group Incentive Program. Medicare participates through MAPCP Demonstration.
New York: Adirondack Region Medical Home Pilot Pods	• 3 pods, • 106,000 eligible patients	• Medicaid, Medicare, private plans, some self-insured employers including state employees	• $7 PMPM payment to providers who contract with pods for support services: Average payment to pod ~ $3.50 PMPM	• Regional pilot • Medicare participates through MAPCP Demonstration.

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Financing Behavioral Health Integration for Medicaid Enrollees: Sec. 2703 Health Homes

Missouri (MOHealthNet) received CMS approval for 2 state plan amendments (2011)

- **Behavioral Health**
  - Health home teams in community mental health centers receive fixed PMPM payment ($78.74)
  - Additional payment funds nurse care management & PCP consultant services, & health home administration
- **Physical Health**
  - Primary care health homes (FQHCs) receive PMPM care management payments totaling $58.87
  - Additional payments fund nurse care management, behavioral health, & care coordination services

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Massachusetts Primary Care Payment Reform Initiative

In partnership with MassHealth PCCM + Medicaid MCOs

- **Comprehensive Primary Care Payment**: risk-adjusted PMPM for primary care services
  - Payments tiered based on level of behavioral health (BH) services provided by practice
    - Tier 1 – No BH services provided
    - Tier 2 – Provide minimum set of BH services + BH provider on-site (master's or doctorate level)
    - Tier 3 – Maximum set of BH services + all Tier 2 requirements + on-site psychiatrist (0.2 FTE), 24/7 access to BH services, and 24/7 provider access to BH record

Practices also receive **Quality Incentive Payments and are eligible for **Shared Savings/Risk Payments** (not specific to BH)

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Arkansas Health Care Payment Improvement Initiative

- Participating payers: Medicaid, AR BlueCross BlueShield, AR QualChoice
- Payment based on **"episodes of care"**
  - 5 episodes currently defined
  - Payers designate 'principal accountable provider' (PAP) for each type of episode (e.g. PAP for hip replacement = orthopedic surgeon)
- Methodology
  - Providers still reimbursed based on existing fee schedule for services delivered
  - Eligible for risk & gain sharing based on *average* cost of care per-episode (assessed yearly based on claims)
  - Gain sharing is dependent on achievement of quality indicators

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Colorado's Accountable Care Collaborative

- Enabled by legislation, the CO ACC went live in 2011.
- Three core components:
  1. Primary Care Medical Providers (PMCP): $4 PMPM plus FFS and performance payments
  2. Regional Care Collaborative Organizations—7 selected through statewide RFA: $13 PMPM plus performance payments
  3. Statewide Data Analytics Contractor: $3 PMPM
- Colorado is focusing on 3 outcome measures to evaluate program:
  1. Emergency Room Visits;
  2. Hospital Re-admissions; and
  3. Outpatient Service Utilization, including diagnostic imaging services.
- Outcomes

Minnesota: Shared Savings in Practice

- Medicaid providers can form accountable care organizations responsible for the total cost of care of their Medicaid patient populations.
- Smaller providers operate under a shared savings model, larger systems operate under a shared risk and shared savings model.

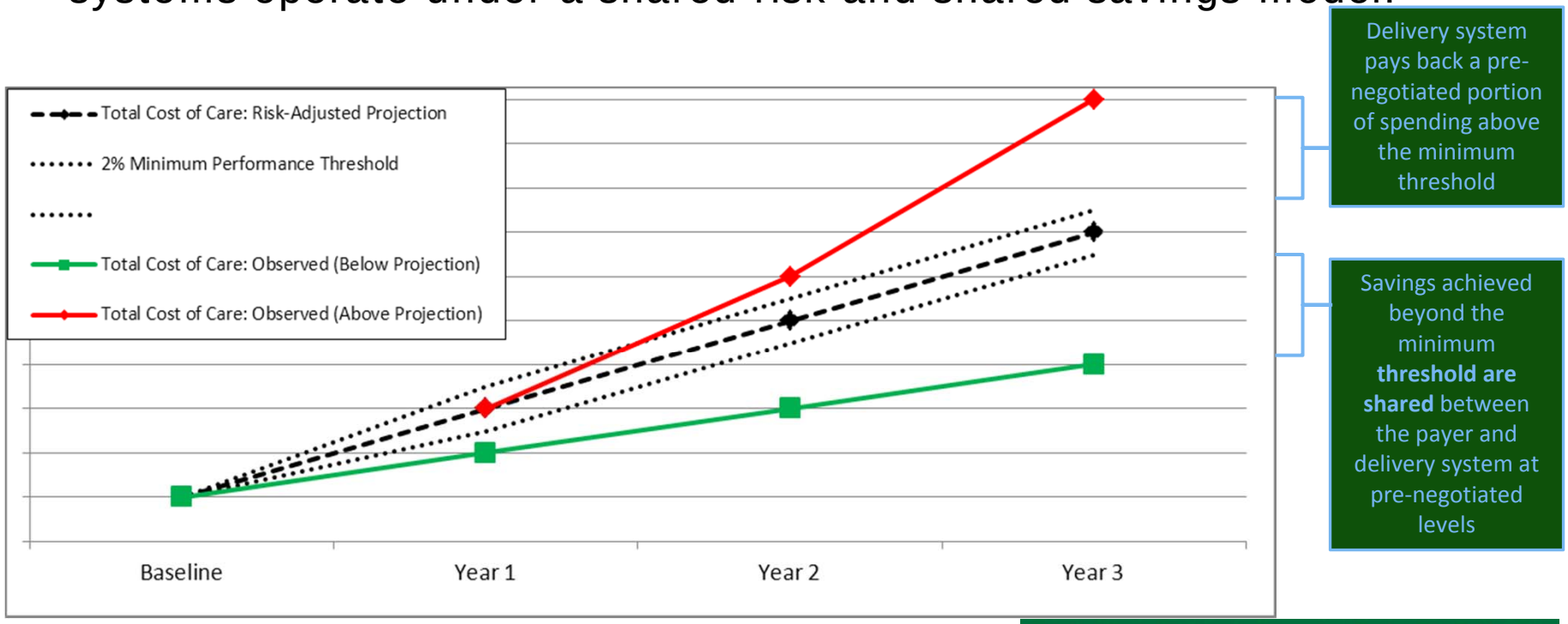

Figure from the Minnesota Department of Human Services

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Oregon Coordinated Care Organizations (CCOs): Payment Model

- CCOs must have capacity to assume risk. Each CCO receives a ***fixed global budget.*** These budgets include:
  - Capitated PMPM for physical, mental, and dental services
  - Transformation incentive payments
  - Medicare funding to blend with Medicaid funding for dual eligibles
- Expected to implement value-based alternatives to traditional FFS reimbursement methodologies (e.g. shared savings, bundled or episode-based payments, and global payments)
- Meet key quality measurements while reducing the growth in spending by 2% over the next 2 years
- OR received SIM Testing grant from CMMI to expand the CCO integrated model to state employees, Medicare for dual eligibles, and commercial payers

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Key takeaways

- Path to integrated care models begins with strong primary care (medical homes)
- Practice training, data analytics, expanded care teams, patient engagement, and community linkages are fundamental to success
- Potential for meeting costs and quality targets in integrated care models are significant
- Shifting the health care system will ultimately depend on integrating public health in these models

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For More Information

Please visit:

- www.nashp.org
- http://www.nashp.org/med-home-map
- http://www.nashp.org/state-accountable-care-activity-map
- www.statereforum.org
- www.pcpcc.net

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